UNITED STATES DISTRICT COURT
DISTRICT OF PUERTO RICO

FAJARDO HOME CARE, INC. et al., Plaintiffs, v. MICHAEL O. LEVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, Defendant.	CIVIL NO. 04-2433 (SEC/JAF)

OPINION AND ORDER

Plaintiffs, Fajardo Home Care, Inc., Font Martello Home Care, Inc., El Gigante Home Care, Inc., and Guaynabo Home Care, Inc., a group of Medicare providers, hereinafter collectively referred to as "Providers," bring this action against Defendant, Michael O. Levitt, Secretary of the United States Department of Health and Human Services ("HHS"), hereinafter referred to as "Secretary," pursuant to 42 U.S.C. §1395oo(b) and (f)(1) and 42 C.F.R. § 405.1877. Docket No. 1. Plaintiff Providers request that this court reverse a decision issued by the Provider Reimbursement Review Board ("Board") disallowing the reimbursement of certain expenses incurred by Providers in the conveyance of accounts receivable. Id.; Docket No. 27. Providers also request an award of interest on the amounts in controversy pursuant to 42 U.S.C. 1395oo(f)(2). Docket No. 1. Defendant Secretary moves for judgment on the pleadings pursuant to

F.R.C.P. 12(c).[1] Docket No. 25. Plaintiff Providers oppose. Docket No. 27.

I.

Statutory and Regulatory Background

This case arises under Title XVIII of the Social Security Act, hereinafter referred to as the "Medicare Act," 42 U.S.C. §§ 1395 *et seq.* (2003 and Supp. I 2008). The Medicare Act established a program for the provision of health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services[2] ("CMS"), an operating division of HHS, administers the Medicare program. Fed. Reg. 35437-03 (July 5, 2001); 42 Fed. Reg. 13262-03 (March 9, 1977). Part A of the Medicare Act, 42 U.S.C. §§ 1395c-1395i-5, authorizes payment to providers of home health services, among other types of providers, for the provision of qualified medical services. 42 U.S.C. §§ 1395x(u), 1395c, 1395g. Plaintiff Providers are "home health

[1] Although disposition of Providers' appeal is before this court on the Secretary's motion for judgment on the pleadings pursuant to Rule 12(c), this court applies the standard of review found in Section 706 of the Administrative Procedures Act, 5 U.S.C. § 706 (2003), and confines its review to the Board's decision and the administrative record. See, e.g., Board of Trustee's of State Institutions of Higher Learning v. Sullivan, 763 F.Supp. 178(S.D.Miss.1991); see also, e.g., Girling Health Care, Inc. v. Shalala, 85 F.3d 211, 214 (5th Cir.1996) (concluding that summary judgment procedure is appropriate in cases where the federal court is asked to review or enforce a decision of a federal administrative agency provided that the court in disposition of the motion does not go beyond the administrative record).

[2] CMS is formerly known as the Health Care Financing Administration. See 66 Fed. Reg. 35437-03 (July 5, 2001), amending 42 Fed. Reg. 13262-03 (March 9, 1977).

agencies" and, therefore, "providers of services" within the meaning of 42 U.S.C. 1395x(u).

"Fiscal intermediaries" are private entities contracted by CMS to manage medicare payments issued to providers in accordance with the Act, regulations adopted pursuant thereto, and guidelines published by CMS, such as the Medicare Provider Reimbursement Manual ("PRM"). Id. § 1395h; 42 C.F.R. §§ 405.1803(b), 421.5, 421.100 (West, through February 20, 2009). The fiscal intermediary makes interim payments to providers based on an estimation of actual costs. 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.64. After the close of a provider's fiscal year, the provider submits an annual cost report to a fiscal intermediary to account for the cost of services allocated to Medicare. 42 C.F.R. § 413.20(b). The fiscal intermediary conducts an audit of the report, determines which costs are "allowable," and, if necessary, makes a retroactive adjustment for overpayment or underpayment. 42 U.S.C. § 1395h, 42 C.F.R. §§ 405.1803(a), 413.64(f). Providers are notified of any retroactive adjustment and monies due or owed through issuance of a Notice of Program Reimbursement ("NPR"). 42 C.F.R. § 405.1803. Future payments to providers may be adjusted to account for past overpayments or underpayments. 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 405.371-73, 405.1803(c), 413.64(f).

A provider who is dissatisfied with a decision of an intermediary on reimbursement of costs, may appeal to the Board

within one-hundred and eighty (180) days after the Intermediary's decision is received. 42 U.S.C. § 1395oo; 42 C.F.R. §§ 405.1835 (a)(3), 405.1837. Groups of providers, such as Plaintiff Providers, may collectively appeal to the Board from an adverse decision of a fiscal intermediary within the same time frame if the controversy involves a common question of fact or interpretation of law or regulations and the total amount in controversy is $50,000 or more. 42 U.S.C. § 1395oo; 42 C.F.R. §§ 405.1835(a)(3), 405.1837. Following an administrative hearing, the Board may affirm, modify or reverse an intermediary's determination. 42 U.S.C. § 1395oo(d); 42 C.F.R. § 405.1871(b)(1).

"A decision of the Board shall be final . . . unless the Secretary reverses, affirms, or modifies the Board's decision" within sixty (60) days after the provider is notified of the Board's decision. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875 (clarifying that discretionary review by the Secretary is actually conducted at the discretion of the Administrator with assistance from the Office of the Attorney Advisor). A provider may obtain judicial review of the Board's or the Secretary's decision pursuant to applicable provisions of the Administrative Procedure Act ("APA"), 5 U.S.C. § 701 *et seq.* See 42 U.S.C. § 1395oo(f)(1); Board of Trustees of State Institutions of Higher Learning, 763 F.Supp. at 182.

A. CMS Guidelines for Reimbursement of Costs Incurred in Accounts Receivable Financing.

The Secretary has issued "certain interpretations of the governing statutes and regulations in the Provider Reimbursement Manual ("PRM")." Board of Trustees of State Institutions of Higher Learning, 763 F.Supp. at 181; PRM, CMS Pub. 15-1. The PRM specifies the conditions under which certain costs incurred in accounts receivable financing constitute allowable expenses and, therefore, may be reimbursed to providers. PRM, CMS Pub 15-1, Chapter 2. Section 219 of the PRM provides that costs associated with the "sale" of accounts receivable are not allowable expenses:

> In accounts receivable financing, the intermediary must first determine if the arrangement represents a sale of receivables or if it is a loan. If it is a loan, interest incurred on the loan is an allowable expense if it is necessary and proper as defined in §§ 202.1, 202.2 and 202.3. The interest on the loan is the discount on the advance on the receivables (*e.g.*, 10 percent where a provider receives 90 cents on the dollar).
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> If the intermediary determines that the arrangement is a sale, *the costs associated with the sale are not allowable expenses*. The provider has opted to receive payment prior to collection on the accounts.

Id. §219 (emphasis supplied). The Medicare Act, regulations adopted pursuant thereto, or the PRM do not define what constitutes a "sale" of accounts receivable, however. The PRM does state that "for any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be

applied." PRM, CMS Pub. 15-1, Chapter 1, at I; AR, at 104-105. Toward that end, Financial Accounting Standard ("FAS") 125, issued by the Financial Accounting Standards Board ("FASB"), provides that "a transfer of financial assets in which the transferor surrenders control over those financial assets shall be accounted for as a sale to the extent that consideration other than beneficial interests in the transferred assets is received in exchange." AR, at 30 (emphasis supplied). Under FAS 125, the transferor is deemed to have "surrendered control" over transferred assets if all of the following conditions are met:

> A. The transferred assets have been isolated from the transferor - put presumptively beyond the reach of the transferor and its creditors, even in bankruptcy or other receivership;
>
> B. Either (1) each transferee obtains the right — free of conditions that constrain it from taking advantage of that right to pledge or exchange the transferred assets or (2) the transferee is a qualifying special-purpose entity and the holders of beneficial interests in that entity have the right — free of conditions that constrain them from taking advantage of that right — to pledge or exchange those interests; and
>
> C. The transferor does not maintain effective control over the transferred assets through (1) an agreement that both entitles and obligates the transferor to repurchase or redeem them before their maturity, or (2) an agreement that entitles the transferor to repurchase or redeem transferred assets that are not readily obtainable.

Id.

II.

Factual and Procedural Background

As required, we derive the following facts from the Administrative Record. Each Provider entered into an Agreement for Funding of Healthcare Receivables ("Agreement") with MedCapital Funding I, Corp. ("MedCap") to obtain financing through the transfer of certain healthcare receivables. AR, at 1390. Paragraph 10.04 of the Agreement states that the Provider, "[u]pon giving thirty (30) days written notice . . . shall have the right to repurchase all, but not less than all of the Healthcare Receivables for a Repurchase Price equal to the then outstanding principal amount of the proceeds." AR, at 243, 446 (emphasis supplied). The Agreements are governed by the laws of the State of Texas. AR, at 245 and 448. Each Provider also entered into an agreement ("MedCare Agreement") with MedCare Financial Solutions, Inc. ("MedCare"), under which MedCare is obligated to take over the preparation, filing, and management of Medicare claims on the accounts receivable transferred under the Agreement. AR, at 1814. As of the effective date of the MedCare Agreement, MedCare controlled when the accounts receivable would be billed to MedCap. AR, at 89.

Providers submitted annual cost reports to Blue Cross and Blue Shield Association for United Government Services ("UGS"), the designated fiscal intermediary, claiming the following interest

expense associated with the transfer of accounts receivable under the Agreements:

(1)	Guaynabo Home Care, Inc., Inc.	$277,697.00
(2)	Font Martello Home Care, Inc.	$1,523.00
(3)	Fajardo Home Care, Inc.	$25,256.00
(4)	El Gigante Home Care, Inc.	$24,097.00

AR, at 1390. UGS audited the Providers cost reports and disallowed the above-listed expense. AR, at 12. UGS based its decision on a determination that the aforementioned transaction constituted a "sale" of Providers' accounts receivable under § 219 of the PRM and FAS 125, for which associated costs are not eligible for reimbursement from Medicare. Id.

Providers appealed UGS' disallowance of claimed interest expense to the Board. AR, at 1767. On January 28, 2004, the Board held a hearing on the limited issue of whether or not the Agreements For Funding of Healthcare Receivables constitute a "sale" of accounts receivable. AR, at 11-15. During the hearing, the Intermediary relied on § 219 of the PRM, CMS Pub. 15-1, and FAS 125 to support its contention that the Providers' Agreements constitute a "sale" of accounts receivable because under the Agreements, Providers "surrendered control" of the accounts receivable. AR, at 13.

Both the Intermediary and the Providers proffered testimony at hearing regarding the three criteria in FAS 125. The Providers argued that the accounts receivable were not in fact "isolated" so as to be

put "presumptively beyond the reach of Providers and its creditor in the event of bankruptcy," as required under para. "A." AR, at 14. In response, the Intermediary argued that the requirements of para. "A" were met because "the Agreement gives MedCap the exclusive right to purchase the receivables and the Providers agree to sell, transfer, assign and convey all their right, title and interest in the receivables." AR, at 13.

Providers argued that the requirements of para. "B" were met because their right to repurchase the accounts receivable under paragraph 10.04 survived assignment and, therefore, MedCapital Funding I, Corp. did not obtain the accounts receivable free and clear, as required under para. "B." AR, at 14. In response, the Intermediary argued that the requirements of para. "B" were met because "the Agreement does not prohibit MedCap from pledging or exchanging the transferred assets." AR, at 13.

The Providers argued that the Agreement did not meet the requirements of para. "C" because Providers did not relinquish "control" with an option to repurchase not less than all of the accounts receivable upon the provision of 30 days notice. AR, at 14. In response, the Intermediary argued that para. "C" is met because no provision within the Agreement "both entitles and obligates the Providers to repurchase the receivables as described in paragraph 'C.'" AR, at 13.

UGS's Audit Manager, Mr. Lukac, and MedCap's CPA, Mr. James, provided testimony during the hearing. On behalf of the Intermediary, Mr. Lukac testified that Medicare made up ninety percent (90%) of the Providers' business and opined that the thirty-day notice requirement under Paragraph 10.04 made the repurchase option ineffective because Medicare claims are usually paid within fourteen (14) days of submission. Id., at 107. On behalf of the Providers, Mr. James testified that even if the date of billing for transferred receivables was immediately after the date of the assignment, it was still possible that payment would extend beyond the 30-day period provided for under Paragraph 10.04. AR, at 90. Notably, no one offered evidence at the hearing to establish the dates on which MedCare actually billed claims for reimbursement on the transferred accounts. Docket No. 27, at 6.

On October 29, 2004, the Board issued its decision upholding the Intermediary's decision to disallow the claimed interest expense. AR, at 11-15 ("the Intermediary's adjustments disallowing the Providers' interest expense were proper and affirmed"). In its decision, the Board reasoned that although the Agreements included a thirty-day buyback provision, "the requirements of that section leave the providers with no real control over the receivables, as the record established that most, if not all, of the receivables are liquidated within 14 days of billing." AR, at 14. The Board concluded that the Providers could not exercise their right to repurchase "all

but not less than all" of the accounts receivable because at least a portion of the receivables would in effect cease to exist before expiration of the thirty-day notice period.

> By the terms of the MedCap agreements, the Providers surrendered control over the financial assets in consideration of payments made at the time of acquisition. While Section 20.04 of the MedCap agreement does permit the Providers, upon 30 days written notice, to repurchase all but not less than all of the receivables, the requirements of that section leave the providers *with no real control* over the receivables, as the record established that most, if not all, of the receivables are liquidated within 14 days of billing. The Intermediary witness testified that approximately 90 percent of the Providers' business was Medicare related, and Medicare generally pays clean claims in 14 days. As a result, the Providers cannot effectively exercise an option to repurchase all but not less than all of the receivables when the Providers must give a full 30-day written notice.

Id. (emphasis suppled).

Providers pursued all available avenues of appeal from the Board's decision. On November 3, 2004, Providers submitted a *Request For Review of Provider Reimbursement Review Board Decision By Administrator,* which the Administrator declined to review. AR, at 01-07. On December 28, 2004, Providers filed their complaint in this court, requesting a reversal of the Board's decision to uphold the intermediary's (UGS's) disallowance of Providers' claimed costs. Docket No. 1. The issue before this court is limited to whether or not the transaction embodied in the Agreement constitutes a sale of

accounts receivable for which expenses are not reimbursable under the Medicare program.

On April 28, 2005, this court ordered Defendant to file its Memorandum of Law in support of Defendant's Answer within sixty days and Plaintiff to file a Reply Memorandum within sixty days after defendant's filing. Docket No. 20. On June 28, 2005, Defendant Secretary filed the *Secretary's Motion For Judgment on The Pleadings and Memorandum Of Law In Support Thereof* pursuant to Fed. R. Civ. P. 12(c). Docket No. 25; supra, note 1. On August 5, 2005, Plaintiffs filed *Plaintiffs' Memorandum of Law in Reply to Defendant's Motion for Judgment on the Pleadings and Memorandum of Law in Support Thereof*. Docket No. 27.

As a preliminary matter, the fleeting analysis in the Board's decision leaves this court with the impression that the Board did not analyze the available facts against the three criteria in FAS 125 in considerable detail, or at least in its written decision. Rather, it appears that the Board engaged in a threshold inquiry as to whether or not the Providers "surrendered control" of the accounts receivable. Although both parties provided testimony relative to the criteria in paragraphs A, B and C of FAS 125, the Board's two-paragraph, eight-sentence analysis offers little in return. AR, at

14. The Board's macro-analysis and its failure to cite[3] to record evidence greatly frustrated this court's review. Unfortunately for Providers, as a general rule, if an agency happens to issue a decision with "'less than ideal clarity,' a reviewing court is not to upset the decision on that account 'if the agency's path may reasonably be discerned.'" Alaska Dept. Of Environmental Conservation v. E.P.A., 540 U.S. 461, 497, 124 S.Ct. 983 (2004) (quoting Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc., 419 U.S. 281, 286, 95 S.Ct. 438, 42 L.Ed.2d 447 (1974)).

III.

Analysis

A. Standard of Judicial Review

Judicial review of final decisions issued by the Board or the Secretary "is governed by 42 U.S.C. 1395oo(f), which incorporates the standards of Section 706 of the Administrative Procedure Act ("APA"), 5 U.S.C. §706." Board of Trustees of State Institutions of Higher Learning, 763 F.Supp. at 184. The APA requires a reviewing court "to set aside agency action, findings and conclusions found to be 'arbitrary, capricious and an abuse of discretion, or otherwise not

[3] Having reviewed the Board's decision, this court is compelled to refer the Board to 42 C.F.R. § 405.1871(a)(4), which states that Board decisions "must include appropriate citations to the record evidence and to the applicable law, regulations, CMS Rulings, and other interpretive rules, general statements of policy, and rules of agency organization, procedure or practice established by CMS." 42 C.F.R. § 405.1871(a)(4)(emphasis supplied).

in accordance with law' or 'unsupported by substantial evidence.'" Id. (citing 5 U.S.C. 706(2)). In reviewing an agency action under the APA, the agency's action is presumed to be valid and the court will not substitute its judgment for that of the agency. Rivera v. Mueller, 2009 WL 303050, *6 (N.D.Ill.). The court's analysis is limited to determining whether or not the agency's decision is "within the bounds of reasoned decisionmaking." Baltimore Gas & Elec. Co. v. Natural Resources Defense Council, 462 U.S. 87, 105, 103 S.Ct. 2246, 76 L.Ed.2d 437 (1983).

In reviewing issues of law, courts must defer to an administrative agency's "reasonable interpretation" of its governing statute, Northwest Environmental Advocates v. U.S. E.P.A., 537 F.3d 1006, 1020 (9th Cir.2008); that interpretation is entitled to "substantial deference." Connecticut Department of Income Maintenance v. Heckler, 471 U.S. 524, 532, 105 S.Ct. 2210, 2214, 85 L.Ed.2d 577 (1985). Similarly, an agency's interpretation of regulation that it promulgates is entitled to "great deference and must be upheld unless it is so plainly erroneous or so inconsistent with either the underlying regulation or statute as to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law." State of Georgia ex rel. Department of Medical Assistance v. Heckler, 768 F.2d 1293, 1298 (11th Cir.1985), *cert. denied*, State of Georgia ex rel. Department of Medical Assistance v. Bowen, 474 U.S. 1059, 106

S.Ct. 803, 88 L.Ed.2d 779 (1986); South Georgia Natural Gas Co. V. F.E.R.C., 699 F.2d 1088, 1090 (11th Cir.1983).

Under the substantial evidence standard, agency decisions are "presumed valid" and the process by which such decisions are reached is accorded great deference. Duckworth v. U.S., 2006 WL 753081, *2. "Substantial evidence means such relevant evidence as 'a reasonable mind might accept as adequate to support a conclusion.'" Id. (quoting *Steadman v. SEC*, 450 U.S. 91, 99, 101 S.Ct. 999, 67 L.Ed.2d (1981)). Reviewing courts should not disturb the judgment of an administrative tribunal and an agency's endorsement of that judgment "so long as the findings are adequately anchored in the record." Id., 2006 WL 753081,*2.

B. Whether The Board's Findings Are Supported By Substantial Evidence.

The Board's brief analysis classifies the Providers' accounts receivable transaction as a "sale" based on a threshold finding under FAS 125 that Providers "surrendered control" of accounts receivable transferred to MedCap. AR, at 12. Providers argued at hearing before the Board and again before this court that they did not "surrender control" because they held an option to repurchase upon giving thirty days written notice. In response, the Secretary argues, in line with the testimony of Mr. James, that Providers would really be unable to repurchase "all but not less than all" of the accounts receivable upon giving thirty days written notice since "Medicare pays clean

claims generally in 14 days" and the claims at issue were Medicare eligible. AR, at 107. The Board would appear to adopt the position of the Intermediary, concluding that "Providers surrendered control" because "Providers cannot effectively exercise an option to repurchase "all but not less than all" of the receivables when the Providers must give a full 30-day written notice" and "Medicare generally pays clean claims in 14 days." AR, at 12. These circumstances, the Board contends, "leave the Providers with no real control." AR, at 12.

Providers now argue on appeal that the Board made the wrong evidentiary inquiry. Specifically, Providers contend that to render the Providers' option to repurchase under Paragraph 10.04 "meaningless," the relevant evidentiary inquiry is not whether "Medicare generally pays clean claims in 14 days," but rather, whether the healthcare receivables are submitted to and paid by Medicare within 14 days of assignment. Docket Nos. 1 and 27 (emphasis supplied). Providers' point is well-taken. Indeed, if Medicare pays claims within fourteen days, a Provider might successfully exercise their option to repurchase all but not less than all of the accounts receivable if they give 30-day written notice at least a few weeks prior to the date upon which MedCare submits claims on those the transferred accounts. While this court understands the Providers' preoccupation with the timing of claims billed and paid, this court is not in a position to second-guess the judgment of the Board. The

court's review under the substantial evidence standard is limited to ensuring that the Board's findings are "adequately anchored in the record." Duckworth v. U.S., 2006 WL 753081, *2. The Board reached a conclusion that the Providers "surrendered control," in part, based on a finding that Medicare generally pays clean claims in fourteen (14) days. The Intermediary clearly provided testimony that Medicare pays claims generally within fourteen days. AR, at 107.

Moreover, the record reflects that MedCare, not the Providers, had control over when claims on the transferred accounts were billed, making the Providers' ability to successfully exercise their option pursuant to Paragraph 10.04 more a matter of chance than will. Although this fact is not expressly mentioned in the Board's decision, it is a fact in the record that may have influenced the Board's ultimate decision as to whether the Providers "surrendered control" of the accounts receivable. For the above reasons, this court finds the Board's decision to be supported by substantial evidence.

C. Whether The Board's Finding That Providers Surrendered Control Over The Accounts Receivable Is Made In Accordance With The Law And Supported By Substantial Evidence.

Providers contend that the Board erred in classifying the accounts receivable transaction as a "sale" under FAS 125 because the decision is based on "an incorrect interpretation of the law as it applies to the facts of this case." Docket Nos. 1 and 27. Specifically, Providers argue that the Board did not properly

consider applicable provisions of the bankruptcy code in its analysis of the criteria in paragraph "A" of FAS 125 and did not interpret Paragraph 10.04 pursuant to the principles of contract construction.

1. Whether The Board Correctly Interpreted And Applied Applicable Provisions Of The Bankruptcy Code.

Providers contend that they did not "surrender control" of the accounts receivable because the accounts receivable were not "isolated" so as to be "put presumptively beyond the reach of the transferor [Providers] and its creditors, even in bankruptcy," a requirement of paragraph "A" in FAS 125. Docket No. 27, at 8; FAS 125(A). This court agrees with Providers' assessment of the Bankruptcy Code, but not their application. Under the Bankruptcy Code, upon the filing of a bankruptcy petition by a Provider, an estate would be created consisting, in part, of "all legal and equitable interest of the debtor in a property." 11 U.S.C. § 541(a)(1). Creditors would be entitled to file claims against an estate of the Provider. Id. § 501(a). Furthermore, upon the filing of a petition, a stay would be effected of "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of estate." Id. § 362(a)(3). Clearly, rights arising in contract, such as the Providers' right to repurchase arising under Paragraph 10.04, are property rights that may, upon the filing of a petition, be included in a Provider's estate.

Providers assert that their right to repurchase the accounts receivable upon giving thirty days written notice pursuant to Paragraph 10.04 would, "upon the filing of a bankruptcy petition, make all accounts receivable a part of the Debtor/Provider's bankruptcy estate" and, therefore, the accounts receivable would not in effect be "isolated" from Providers or their Creditors. Docket No. 27, at 10. To the extent that Providers contend the accounts receivable would be included in the bankruptcy estate, this court must disagree. The property right subject to the claims of creditors in a bankruptcy proceeding cannot exceed the right held by the debtor. The "property right" at issue here is a Provider's right to repurchase not less than all of the accounts receivable upon giving thirty days written notice. Contrary to Providers' assertion, it is not the accounts receivable, but rather, the right to repurchase those receivables, that would be subject to inclusion in a bankruptcy estate. See also, e.g., In re Stevens, 374 B.R. 31 (D.N.H.2007) (holding that residence was not property of the bankruptcy estate but debtors state law statutory right to repurchase residence was an interest in property that they had on petition date, and that did become "property of the estate").

The Board determined that Providers had no "real control" over the accounts receivable and, therefore, effectively "surrendered control" upon execution of the Agreement. Having considered the record in its entirety, this court finds the Board's decision to be

reasonable. Creditors would inevitably succeed to the same right held by Provider-debtors in the event of bankruptcy. That right to repurchase, if claimed, would, therefore, also be presumptively beyond the reach of creditors. This court finds the Board's determination to be in accordance with the Code and within the bounds of reasoned decision-making.

2. Whether The Board's Interpretation of Paragraph 10.04 Is In Accord With Principles of Contract Construction.

Providers argue under the principles of contract construction that the Board misinterpreted the operation of Paragraph 10.04 and, consequently, erred in determining that the accounts receivable were "isolated from the transferor . . . beyond the reach of the transferor and its creditors, even in bankruptcy." Docket No. 27, at 13-14. Paragraph 10.4 provides:

> Upon giving thirty (30) days written notice to MEDCAPITAL, PROVIDER shall have the right to repurchase all, but not less than all, of the Healthcare Receivables for a Repurchase Price equal to the then outstanding principal amount of the proceeds.

Providers argue that the Board interpreted Paragraph 10.04 incorrectly. The Providers would interpret Paragraph 10.04 such that the "then outstanding principal amount" relates to the date of the notice, securing a right to repurchase the outstanding accounts receivables that exist on the date of notice. Docket No. 27, at 13. This interpretation would, of course, make it more feasible for providers to exercise their option to repurchase "all but not less

than all" of the accounts receivable because MedCare would have less time to submit and receive payment for claims submitted on the transferred accounts.

This court can only presume from the Board's decision that it would advocate for an interpretation of Paragraph 10.04 that relates the "then outstanding principal amount" to the amount in existence at the end of the thirty-day notice period. This interpretation would, of course, diminish the Providers' ability to repurchase not less than all of the accounts receivable, because MedCare would have more time during which to bill and receive payment for claims submitted on the transferred accounts.

Providers assert that their interpretation is correct and should be adopted because the alternative would render Paragraph 10.04 meaningless. Docket No. 27, at 13, 14. It is well-established that contracts should be construed so as to give all provisions meaning and allow for the possibility of performance. Coker v. Coker, 650 S.W.2d 391, 393; Republic National Bank of Dallas v. Northwest National Bank of Fort Worth, 578 S.W.2d 109, 115 (Tex 1978). But, in this case, under the Board's interpretation of Paragraph 10.04, it is not clear that Paragraph 10.04 would be rendered meaningless or ineffective. The Board's interpretation would, however, make the option to repurchase no less than all of the accounts receivable exceedingly difficult to exercise and ultimately contingent upon the timing of actions performed by third-parties (*e.g.*, MedCare and CMS

claims Dept.). It is discernable under these facts how the Board might have concluded that the Providers "surrendered control" of the accounts receivable. As such, this court defers to the Board's interpretation of Paragraph 10.04.

IV.

Conclusion

For the foregoing reasons, this court finds on the record before it, that the decision of the Board is supported by substantial evidence, and made in accordance with the law. Accordingly, the court hereby **AFFIRMS** the decision of the Board. Case closed.

IT IS SO ORDERED.

San Juan, Puerto Rico, this 16th day of March, 2009.

s/José Antonio Fusté
JOSE ANTONIO FUSTE
Chief U.S. District Judge